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Updated March 29, 2017

Frequently Asked Questions About Medicaid

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Recent proposals to radically restructure Medicaid raise questions about how the program works and its current role for states, beneficiaries, and health care providers and plans. This report addresses some of these questions.[1]

How Efficient Is Medicaid?

Medicaid's costs per beneficiary are substantially lower than for private insurance and have been growing more slowly than per-beneficiary costs under private employer coverage.

Medicaid provides more comprehensive benefits than private insurance at significantly lower out-of-pocket cost to beneficiaries, but its lower payment rates to health care providers and lower administrative costs make the program very efficient. It costs Medicaid much less than private insurance to cover people of similar health status. For example, adults on Medicaid cost about 22 percent less than if they were covered by private insurance, Urban Institute research shows.[2]

Over the past 30 years, Medicaid costs per beneficiary have essentially tracked costs in the health care system as a whole, public and private. In fact, costs per beneficiary grew much more slowly for Medicaid than for private insurance between 1987 and 2014 (see Figure 1), and are expected to continue growing more slowly than for private insurance in coming years, according to the Medicaid and CHIP Payment and Access Commission.[3]

[1] See also Matt Broaddus and Edwin Park, "Ryan Poverty Report's Criticism of Medicaid Misrepresents Research Literature," Center on Budget and Policy Priorities, March 31, 2014, http://www.cbpp.org/cms/index.cfm?fa=view&id=4114.

[2] Teresa Coughlin *et al.,* "What Difference Does Medicaid Make? Assessing Cost-Effectiveness, Access and Financial Protection under Medicaid for Low-Income Adults," Kaiser Family Foundation, May 3, 2013, http://kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/.

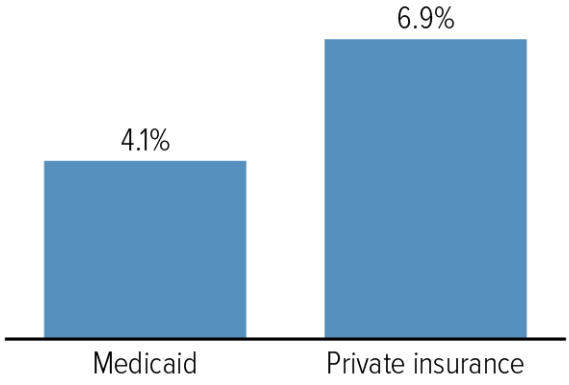
[3] Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP," June 2016, https://www.macpac.gov/wp-content/uploads/2016/06/Trends-in-Medicaid-Spending.pdf.

Moreover, the Congressional Budget Office (CBO) has lowered its projection of Medicaid spending for the decade from 2011 to 2020 by $311 billion — or 9.3 percent — since 2010, largely due to slower expected growth in per-beneficiary costs.[4] These projections exclude the Affordable Care Act's (ACA) Medicaid expansion.

FIGURE 1

Medicaid Spending per Beneficiary Has Grown More Slowly Than Private Insurance

Average annual growth rate per enrollee, 1987-2015



Source: Centers for Medicare & Medicaid Services, National Health Expenditure Tables, December 2016, Table 21

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How Much Flexibility Do States Have to Design Their Own Programs?

Medicaid gives states expansive flexibility to design their own programs — whom they cover, what benefits they provide, and how they deliver health care services.

The federal government sets minimum standards, including specifying certain categories of people that all states must cover and certain health coverage they must provide. Beyond that, states are free to set their own rules. For example, states have broad flexibility to decide which "optional" categories of low-income people to cover, and up to what income levels. As a result, Medicaid eligibility varies substantially from state to state.

Medicaid benefit packages vary significantly by state as well. States have flexibility to determine whether to cover services like dental and vision care for adults and can determine the amount, duration, and scope of the services they provide.

States also have flexibility over how they deliver health care services. Some states rely heavily on managed care plans to deliver care, while others use provider-sponsored organizations, health homes, and accountable care organizations.[5]

Medicaid is the primary payer for long-term services and supports, including nursing home care and home health services, the need for which is expected to grow considerably as the population ages.[6] Using Medicaid's flexibility — including a number of new state options created by the ACA — states have greatly expanded home- and community-based services (HCBS) so more people with

[4] CBPP analysis comparing CBO's August 2010 and January 2017 Medicaid and Affordable Care Act baselines.

[5] Kaiser Family Foundation, "Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts," June 2015, http://kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/.

[6] Erica L. Reaves and MaryBeth Musumeci, "Medicaid and Long-Term Services and Supports: A Primer," Kaiser Family Foundation, December 15, 2015, http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

long-term service and support needs can stay in their homes and communities rather than nursing homes and other institutions. The share of Medicaid spending on long-term services and supports going to HCBS rose from 18 percent to 53 percent between 1995 and 2014.[7]

States have taken advantage of Medicaid's flexibility in other ways to improve beneficiary health outcomes while lowering costs.[8] Many of these states have employed strategies to improve the delivery of care, particularly for beneficiaries with chronic conditions who use the most care.[9] For example, a Wisconsin hospital is testing a new way to integrate health services for Medicaid-eligible children with complex medical needs, a rapidly growing group with high health care costs.[10] An early evaluation of Wisconsin's model showed that inpatient hospital days and costs fell by more than 50 percent after children enrolled in the program.[11]

Similarly, Oregon has established, through a Medicaid waiver, a network of accountable care organizations — groups of providers and other entities that partner to provide a range of health care services in a coordinated way — to integrate hospital-based services with primary care, behavioral health care, and other social supports.[12] Oregon has seen emergency department visits and preventable hospital admissions fall significantly, while lowering its growth in Medicaid spending per beneficiary by two percentage points below the levels projected without the waiver.[13]

Do Beneficiaries Have Adequate Access to Health Care?

Numerous studies show that Medicaid has helped make millions of Americans healthier by improving access to preventive and primary care and by protecting against (and providing care for) serious diseases.

Notably, a landmark study of Oregon's Medicaid program found that, compared with similar people without coverage, people with Medicaid were 40 percent less likely to have suffered a decline

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[7] Judith Solomon, "Caps on Federal Medicaid Funding Would Give States Flexibility to Cut, Stymie Innovation," Center on Budget and Policy Priorities, January 18, 2017, http://www.cbpp.org/research/health/caps-on-federal-medicaid-funding-would-give-states-flexibility-to-cut-stymie.

[8] Hannah Katch, "States are Using Flexibility to Create Successful, Innovative Medicaid Programs," Center on Budget and Policy Priorities, June 13, 2016, http://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs.

[9] Centers for Medicare & Medicaid Services, "Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality," CMCS Information Bulletin, July 24, 2013, http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf.

[10] Center for Medicare and Medicaid Innovation, "Health Care Innovation Awards Round Two Project Profiles," July 2014, https://innovation.cms.gov/Files/x/HCIATwoPrjProCombined.pdf.

[11] John B. Gordon *et al.,* "A Tertiary Care-Primary Care Partnership Model for Medically Complex and Fragile Children and Youth with Special Health Care Needs," *JAMA Pediatrics,* October 2007.

[12] State of Oregon, 1115 Waiver Demonstration Renewal, https://www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf.

[13] Sarah Klein, Douglas McCarthy, and Alexander Cohen, "Health Share of Oregon: A Community-Oriented Approach to Accountable Care for Medicaid Beneficiaries," Commonwealth Fund, October 2014, http://www.commonwealthfund.org/~/media/files/publications/case-study/2014/oct/1769_klein_hlt_share_oregon_aco_case_study.pdf.

in their health in the previous six months.[14] They were also more likely to use preventive care (such as cholesterol screenings), to have a regular office or clinic where they could receive primary care, and to receive diagnosis of and treatment for depression and diabetes.[15] In addition, research published in the *New England Journal of Medicine* reported that expansions of Medicaid coverage for low-income adults in Arizona, Maine, and New York reduced mortality by 6.1 percent.[16]

Moreover, people with Medicaid in Oregon were 40 percent less likely than those without insurance to go into medical debt or leave other bills unpaid in order to cover medical expenses. In fact, the latest research from Oregon found that Medicaid coverage "nearly eliminated catastrophic out-of-pocket medical expenditures."[17]

Urban Institute researchers also have found that Medicaid provides beneficiaries with access to health care services that is comparable to — but less costly on an out-of-pocket basis than — what they would receive through employer-sponsored insurance. If these beneficiaries were uninsured, they would be significantly less likely to have a usual source of care and more likely to forgo needed health care services.[18]

The Medicaid and CHIP Payment Access Commission also finds that access to health care is significantly better among non-elderly adult Medicaid beneficiaries than among the uninsured. Some 85 percent of non-elderly adult Medicaid beneficiaries have a regular source of care, nearly twice the figure for non-elderly adults without coverage. Similarly, Medicaid beneficiaries are much more likely to visit a primary care physician, to visit a specialist, and to have a routine check-up.[19]

The ACA's Medicaid expansion is improving the health and financial well-being of those who newly gain coverage as well, research shows. A study comparing low-income adults in Arkansas and Kentucky (which adopted the expansion) with similar adults in Texas (which has not expanded) found the expansion has increased utilization of primary care and screenings and treatment for chronic conditions like diabetes. It has also resulted in fewer skipped medications due to cost, lower

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[14] Amy Finkelstein *et al.,* "The Oregon Health Insurance Experiment: Evidence from the First Year," National Bureau of Economic Research Working Paper No. 17190, July 2011, http://www.nber.org/papers/w17190. See also Judith Solomon, "Does Medicaid Matter? New Study Shows How Much," Center on Budget and Policy Priorities, July 7, 2011, http://www.cbpp.org/blog/does-medicaid-matter-new-study-shows-how-much.

[15] Katherine Baicker *et al.,* "The Oregon Experiment — Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine,* May 2, 2013, 368:1713-1722.

[16] Benjamin Sommers, Katherine Baicker, and Arnold Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," *New England Journal of Medicine,* September 13, 2012, 367:1025-1034.

[17] Baicker *et al.*

[18] Coughlin *et al.*

[19] "MACStats: Medicaid and CHIP Data Book," Medicaid and CHIP Payment and Access Commission, December 2016, https://www.macpac.gov/wp-content/uploads/2016/12/MACStats_DataBook_Dec2016.pdf. See also David Blumenthal *et al.,* "Does Medicaid Make a Difference? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014," Commonwealth Fund, June 2015, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jun/1825_blumenthal_does_medicaid_make_a_difference_ib_v2.pdf.

out-of-pocket medical spending, and improved overall health. Moreover, the benefits of the Medicaid expansion grew in its second year of implementation, the study found.[20]

Finally, obtaining access to health care through Medicaid offers long-term benefits. For example, for African American children, Medicaid eligibility during early childhood reduced mortality rates in their later teenage years by 13 to 20 percent, research from the National Institute for Child Health and Human Development finds.[21] In addition, African Americans eligible for Medicaid for more of their childhood have fewer hospitalizations and emergency room visits as adults. And children eligible for Medicaid for more of their childhood earn more as adults and are more likely to attend and complete college.[22]

How Does the ACA's Medicaid Expansion Affect Work Incentives?

The ACA's Medicaid expansion significantly reduces work disincentives among working-poor parents. In states that have adopted the expansion, poor parents can earn substantially more and still retain Medicaid.[23]

Before the expansion took effect in 2014, Medicaid eligibility for working parents cut off at just 61 percent of the poverty line in the typical state, or roughly $12,500 for a family of three in 2017.[24] As a result, a poor parent would lose Medicaid if she worked more hours or took a higher-paying job, though her children would still be eligible for Medicaid or the Children's Health Insurance Program (CHIP). She could receive transitional Medicaid for a limited time but would likely end up uninsured if her employer didn't offer job-based coverage (most very low-wage jobs don't come with health coverage) or she couldn't afford it.

Now, in the 31 states and the District of Columbia that have expanded Medicaid under the ACA, the Medicaid eligibility limit for working parents is 138 percent of the poverty line, about $16,600 for an individual and $28,200 for a family of three in 2017. If a family's income rises above this level, the working parent can get subsidized coverage through the health insurance marketplaces.

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[20] Benjamin Sommers *et al.*, "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *JAMA Internal Medicine*, August 8, 2016, http://archinte.jamanetwork.com/article.aspx?articleid=2542420.

[21] Bruce Meyer and Laura Wherry, "Saving Teens: Using a Policy Discontinuity to Estimate the Effects of Medicaid Eligibility," National Bureau of Economic Research, August 2012, http://www.nber.org/papers/w18309.pdf.

[22] Matt Broaddus, "Medicaid's Long-Term Earnings and Health Benefits," Center on Budget and Policy Priorities, May 12, 2015, http://www.cbpp.org/blog/medicaids-long-term-earnings-and-health-benefits. See also Sarah Cohodes *et al.,* "The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions," National Bureau of Economic Research, May 2014, http://www.nber.org/papers/w20178.pdf.

[23] Jesse Cross-Call, "Don't Reverse Health Reform's Provisions That Boost Work Incentives, Eliminating the Medicaid 'Cliff,'" Center on Budget and Policy Priorities, June 10, 2016, http://www.cbpp.org/blog/dont-reverse-health-reforms-provisions-that-boost-work-incentives-eliminating-the-medicaid.

[24] Martha Heberlein *et al.,* "Getting Into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013," Kaiser Family Foundation, January 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf.

Thus, the Medicaid expansion enables tens of millions of working parents to seek higher wages or to work more hours without forgoing health coverage. As CBO states, "some people who would have been eligible for Medicaid under prior law — in particular, working parents with very low income — will work more as a result of the [health reform] provisions."[25]

Expanding coverage to non-disabled, low-income adults *without* children, most of whom have never been eligible for Medicaid, would likely have little effect on their work incentives. For example, using data from the Oregon Health Study, researchers found no statistically significant difference between a group of low-income adults selected for Medicaid and a control group that remained on a waiting list and uninsured, either in the share with earnings or in the amount of earnings.[26]

Two recent studies comparing changes in the labor market participation of low-income adults in expansion and non-expansion states show that the expansion has *not* reduced work among those newly eligible. The first study finds that low-income workers in expansion states *did not* lose jobs, switch jobs, or change from full- to part-time work more frequently than low-income workers in non-expansion states.[27] The second study similarly shows that the Medicaid expansion did not meaningfully affect the incidence of job loss, the amount of hours usually worked, or the probability of working more than 30 hours.[28]

Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.[29] States can further encourage work among Medicaid beneficiaries by offering supportive employment services. For example, in 2007, Iowa became the first state to amend its Medicaid state plan to include a supportive employment program. The state receives federal Medicaid dollars to help those with a mental illness find and maintain employment by offering skills assessment, assistance with job search and completing job applications, job training, and negotiation with prospective employers. Other states have since followed Iowa's lead, including California, Delaware, Mississippi, and Wisconsin.

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[25] Congressional Budget Office, "Labor Market Effects of the Affordable Care Act: Updated Estimates," February 2014, http://cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf.

[26] Matt Broaddus, "Medicaid Coverage Doesn't Discourage Employment, New Study Shows," Center on Budget and Policy Priorities, October 28, 2013, http://www.cbpp.org/blog/medicaid-coverage-doesnt-discourage-employment-new-study-shows.

[27] Angshuman Gooptu *et al.,* "Medicaid Expansion Did Not Result in Significant Employment Changes or Job Reductions in 2014," *Health Affairs,* 35, no.1 (January 2016): 111-118, http://content.healthaffairs.org/content/35/1/111.full.html.

[28] Robert Kaestner *et al.,* "Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply," National Bureau of Economic Research, Working Paper 21836, December 2015, http://www.nber.org/papers/w21836.

[29] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

Some states have proposed adding a work requirement to their Medicaid programs, which would bar people who fail to work or volunteer a certain number of hours per week from enrolling in Medicaid. Contrary to proponents' claims, however, a work requirement would likely reduce the number of Medicaid beneficiaries *without* increasing employment among poor families.[30] Many adults on Medicaid have disabilities or are caring for a family member; many others have low-wage jobs that don't offer health coverage. Some 87 percent of adults covered by the ACA's Medicaid's expansion are disabled, working, in school, or seeking work; of the remaining 13 percent, three-fourths are caring for family members and the rest report other reasons for their unemployment, such as being laid off from their job.[31]

For those who can work, Medicaid coverage helps them keep their job or search for work. Three-quarters of expansion enrollees in Ohio who were looking for work reported that Medicaid made it easier to do so, and more than half of those who were working said that Medicaid made it easier to keep their jobs.[32]

Some who inaccurately claim the Medicaid expansion discourages work call for repealing health reform and block-granting Medicaid, which would *increase* work disincentives, particularly among poor parents with serious medical conditions and other ongoing health care needs. Medicaid income limits for working parents would likely be even lower under a block grant (or a per-capita cap with reduced federal funding) than they were before the ACA.[33] Working parents thus would have an incentive to cut their hours and earnings in order to retain Medicaid as states cut back their Medicaid programs to fit within their shrunken block-grant funding.

How Does the ACA's Medicaid Expansion Affect State Budgets?

Increasing evidence shows that the Medicaid expansion has not only helped millions of low-income people gain health coverage but also produced state savings.[34]

The ACA calls for the federal government to pick up 100 percent of the expansion's cost through 2016 and at least 90 percent thereafter. The federal share will average roughly 95 percent from 2016 to 2025, according to CBO estimates from 2015.[35] CBO also estimated that states will spend just *1.6 percent* more on Medicaid and CHIP with the expansion than they would

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[30] Hannah Katch, "Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment," Center on Budget and Policy Priorities, July 2016, http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly.

[31] Leighton Ku and Erin Brantley, "Myths About the Medicaid Expansion and the 'Able Bodied,'" *Health Affairs,* March 2017, http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied/.

[32] Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," January 2017, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[33] Edwin Park and Judith Solomon, "Per Capita Caps or Block Grants Would Lead to Large and Growing Cuts in State Medicaid Programs," Center on Budget and Policy Priorities, June 22, 2016, http://www.cbpp.org/research/health/per-capita-caps-or-block-grants-would-lead-to-large-and-growing-cuts-in-state.

[34] Jesse Cross-Call, "Medicaid Expansion Producing State Savings and Connecting Vulnerable Groups to Care," Center on Budget and Policy Priorities, June 15, 2016, http://www.cbpp.org/research/health/medicaid-expansion-producing-state-savings-and-connecting-vulnerable-groups-to-care.

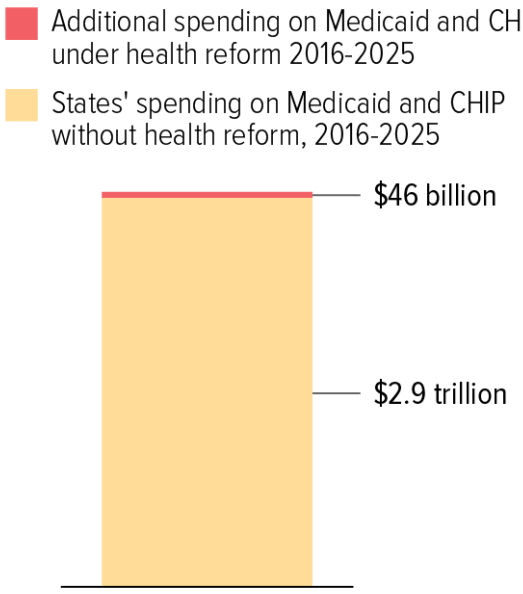
[35] CBPP analysis using CBO's March 2015 Medicaid and CHIP baselines.

have without health reform, under an assumption that most states adopt the expansion (see Figure 2).

In many states the expansion has produced net budgetary savings by allowing the state to move people who previously received health services through targeted Medicaid programs financed at the state's regular match rate, such as family-planning services and care for certain women with breast and cervical cancer, into the new expansion group, for which the federal government pays nearly all of the cost. And as more low-income uninsured residents have gained coverage, demand for entirely state-funded services that serve the uninsured has declined, such as funding for hospitals' uncompensated care costs and for mental health services, has declined.[36] This means that Arkansas, Kentucky, and other states expect the expansion to continue to produce net budgetary savings even after states began paying a modest share of the expansion costs starting in 2017.

FIGURE 2

Medicaid Expansion Raises State Medicaid and CHIP Spending by Only 1.6 Percent



CHIP=Children's Health Insurance Program

Source: CBPP analysis of the Congressional Budget Office's March 2015 Medicaid and CHIP baselines.

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Conversely, repealing the expansion — or reducing federal support for the expansion and effectively ending it — would severely harm state budgets.[37] The number of uninsured would rise substantially, and states and localities would have to spend more of their own money to cover the resulting increases in uncompensated care. And as enrollment in managed care plans dropped, states would collect less premium tax revenue from these plans. Many states would find it harder to not only provide funding for health services for low-income people, but also to adequately fund education, infrastructure, and other non-health priorities.[38]

[36] States have also been able to shift beneficiaries receiving only limited services through targeted Medicaid programs for the uninsured (which are financed at the state's regular Medicaid matching rate) into the Medicaid expansion, financed at the higher expansion matching rate. Cross-Call, "Medicaid Expansion Producing State Savings and Connecting Vulnerable Groups to Care."

[37] See, for example, Edwin Park *et al.*, "Updated House ACA Repeal Bill Deepens Damaging Medicaid Cuts for Low-Income Individuals and Families," Center on Budget and Policy Priorities, March 21, 2017, http://www.cbpp.org/research/health/updated-house-aca-repeal-bill-deepens-damaging-medicaid-cuts-for-low-income.

[38] For more information on how repealing the Medicaid expansion would affect states, see Jesse Cross-Call, "Repealing Health Reform's Medicaid Expansion Would Cause Millions to Lose Coverage, Harm State Budgets," Center on Budget and Policy Priorities, December 22, 2016, http://www.cbpp.org/research/health/repealing-health-reforms-medicaid-expansion-would-cause-millions-to-lose-coverage.

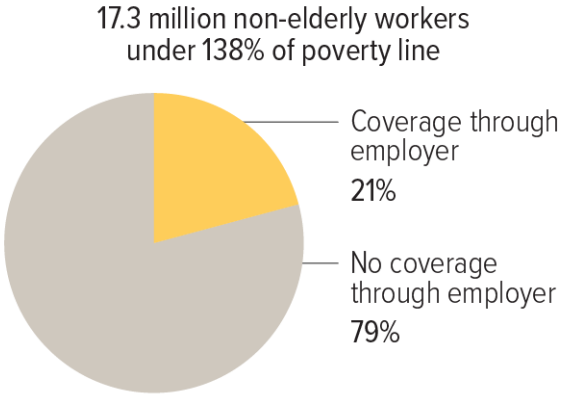
Does Medicaid Primarily Cover People Who Otherwise Would Have Private Coverage?

The overwhelming majority of people who would get coverage under the ACA's Medicaid expansion are low-income and uninsured individuals who generally can't afford private health care. Many of them work in low-wage jobs for small firms or service industries that typically don't offer health insurance. And unsubsidized coverage in the individual insurance market would be unaffordable for most of those eligible for the Medicaid expansion.

- 79 percent of workers earning less than 138 percent of the poverty line — the threshold for qualifying for Medicaid under the Medicaid expansion — do not get coverage through their employer (see Figure 3).

FIGURE 3

Fewer Than 1 in 4 Low-income Workers Get Health Insurance Through Their Jobs



Source: CBPP analysis using 2016 Census Bureau data

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- The median annual cost of single coverage in the pre-ACA individual market, including premiums and out-of-pocket costs, would have consumed more than *one-third of the total income* of a family of three at the poverty line, making such coverage essentially unaffordable.

States that expanded Medicaid before the ACA by raising income eligibility levels for adults reduced the ranks of the uninsured *without* undermining private coverage.[39] Compared to states that did not expand, expansion states had about the same proportion of Medicaid-eligible adults with private coverage but a much lower proportion of uninsured low-income residents.

What Share of Eligible People Participate in Medicaid?

Medicaid participation is quite high, particularly among children in states that have made concerted efforts to simplify and streamline their enrollment processes. For example, prior to the Medicaid expansion, some 66 percent of low-income adults with children who are eligible for Medicaid were enrolled, according to the Urban Institute,[40] a relatively strong participation rate compared to some other programs.[41] And 11.1 million low-income adults newly eligible under the

[39] Matt Broaddus and January Angeles, "Medicaid Expansion in Health Reform Not Likely to 'Crowd Out' Private Insurance," Center on Budget and Policy Priorities, June 22, 2010, http://www.cbpp.org/cms/?fa=view&id=3218.

[40] Genevieve Kenney *et al.,* "Medicaid/CHIP Participation Among Children and Parents," Urban Institute, December 2012, http://www.urban.org/UploadedPDF/412719-Medicaid-CHIP-Participation-Among-Children-and-Parents.pdf.

[41] Government Accountability Office, "Means-Tested Programs: Information on Program Access Can Be an Important Management Tool," March 2005, http://www.gao.gov/assets/250/245577.pdf.

Medicaid expansion had enrolled by the end of 2015, along with an additional 3.5 million individuals who were previously eligible but unenrolled and enrolled due to the Medicaid expansion.[42]

In addition, 91 percent of eligible *children* participated in Medicaid or CHIP in 2014, according to the Urban Institute.[43] That is an exceedingly high rate for a means-tested program; in a number of states, children's Medicaid participation matches or exceeds the participation rates for universal social insurance programs like Medicare Part B.[44] Since CHIP's enactment in 1997, states have taken a number of steps to boost Medicaid and CHIP enrollment among eligible children, such as streamlining application procedures. The ACA requires states to take additional steps to increase the percentage of eligible children enrolling.

Focus groups with low-income, uninsured adults that the Kaiser Family Foundation conducted also bear on this issue. They found no evidence that Medicaid carries a "stigma" that discourages eligible people from enrolling. To the contrary, adults in Nevada, Texas, Florida, and Ohio — all states with very limited Medicaid eligibility before the ACA — said they were eager to enroll in Medicaid. While they wished their financial circumstances were better, they wanted affordable coverage and often couldn't get it from their employers. Furthermore, focus group members with previous experience with Medicaid (often because their children were eligible) spoke favorably of it as affordable and covering a broad set of services and medications.[45]

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[42] Centers for Medicare & Medicaid Services, "Total Medicaid Enrollees – VIII Group Break Out Report, March 2016," December 2016, https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2016.pdf.

[43] Genevieve Kenney *et al.,* "Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation Under the ACA," Urban Institute and Robert Wood Johnson Foundation, May 2016, http://www.urban.org/research/publication/childrens-coverage-climb-continues-uninsurance-and-medicaidchip-eligibility-and-participation-under-aca/view/full_report.

[44] Dahlia Remler and Sherry Glied, "What Other Programs Can Teach Us: Improving Participation in Health Insurance Programs," *American Journal of Public Health,* January 2003, http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.1.67.

[45] Kaiser Family Foundation, "Faces of the Medicaid Expansion: Experiences of Uninsured Adults Who Could Gain Coverage," November 2012, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8385.pdf.